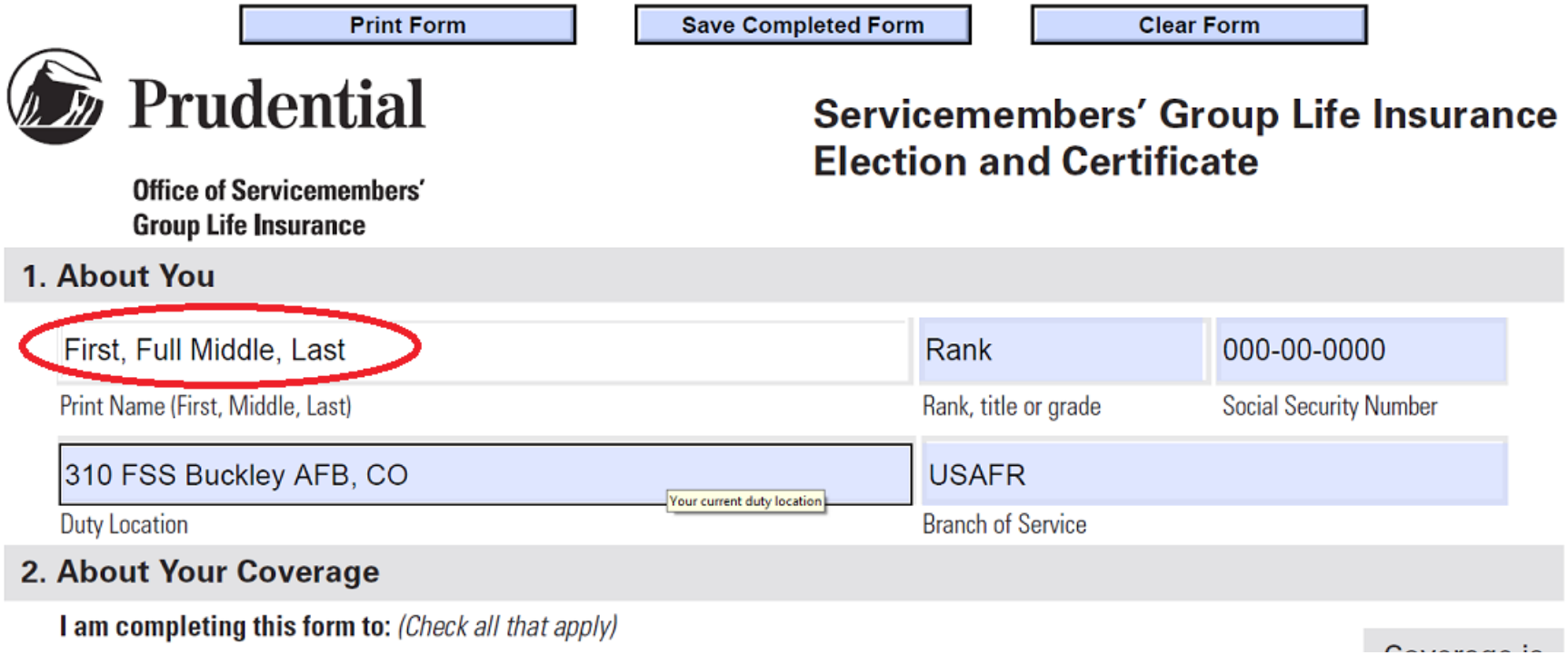
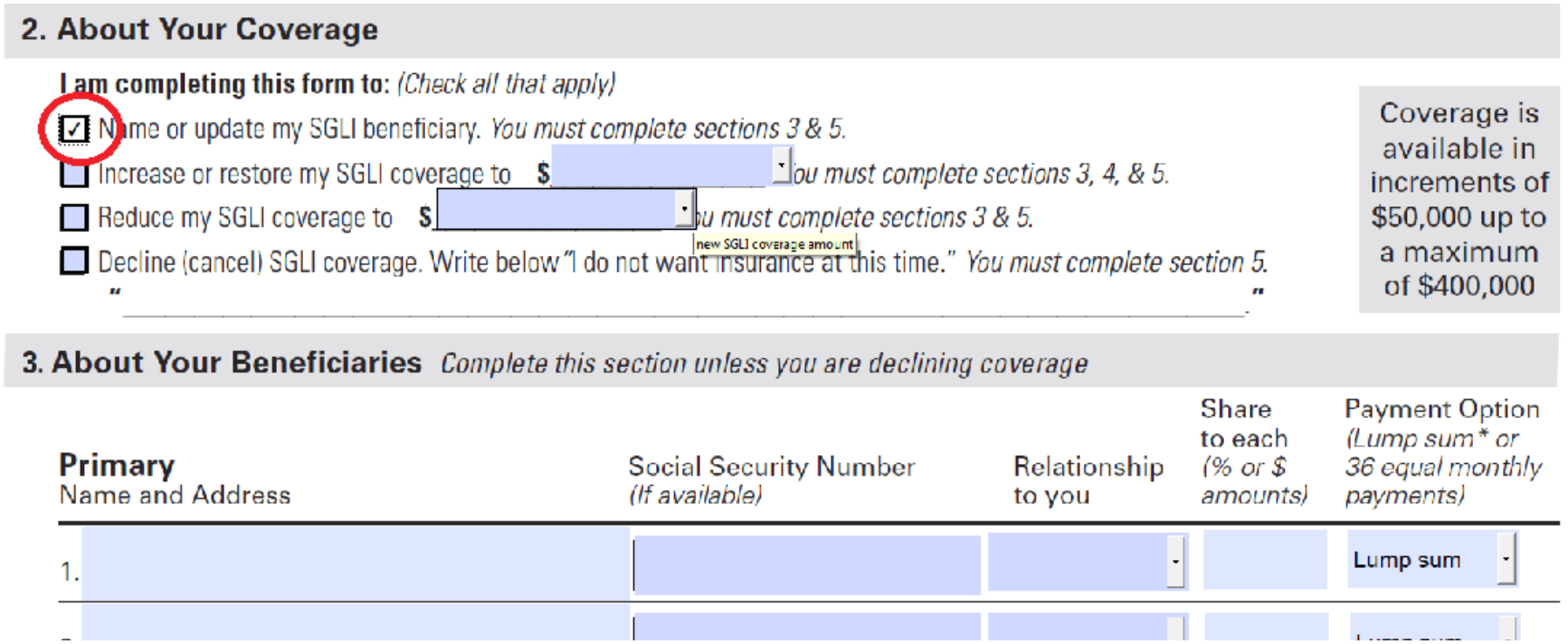
SGLI Directions

Please list FULL First, Middle, and Last names



Name/Update Beneficiaries

For those who are not changing amount of coverage



2. About Your Coverage

I am completing this form to: *(Check all that apply)*

- [x] Name or update my SGLI beneficiary. *You must complete sections 3 & 5.*
- [ ] Increase or restore my SGLI coverage to $ *ou must complete sections 3, 4, & 5.*
- [ ] Reduce my SGLI coverage to $ *u must complete sections 3 & 5.*
- [ ] Decline (cancel) SGLI coverage. Write below "I do not want insurance at this time." *You must complete section 5.*

new SGLI coverage amount

"_____"

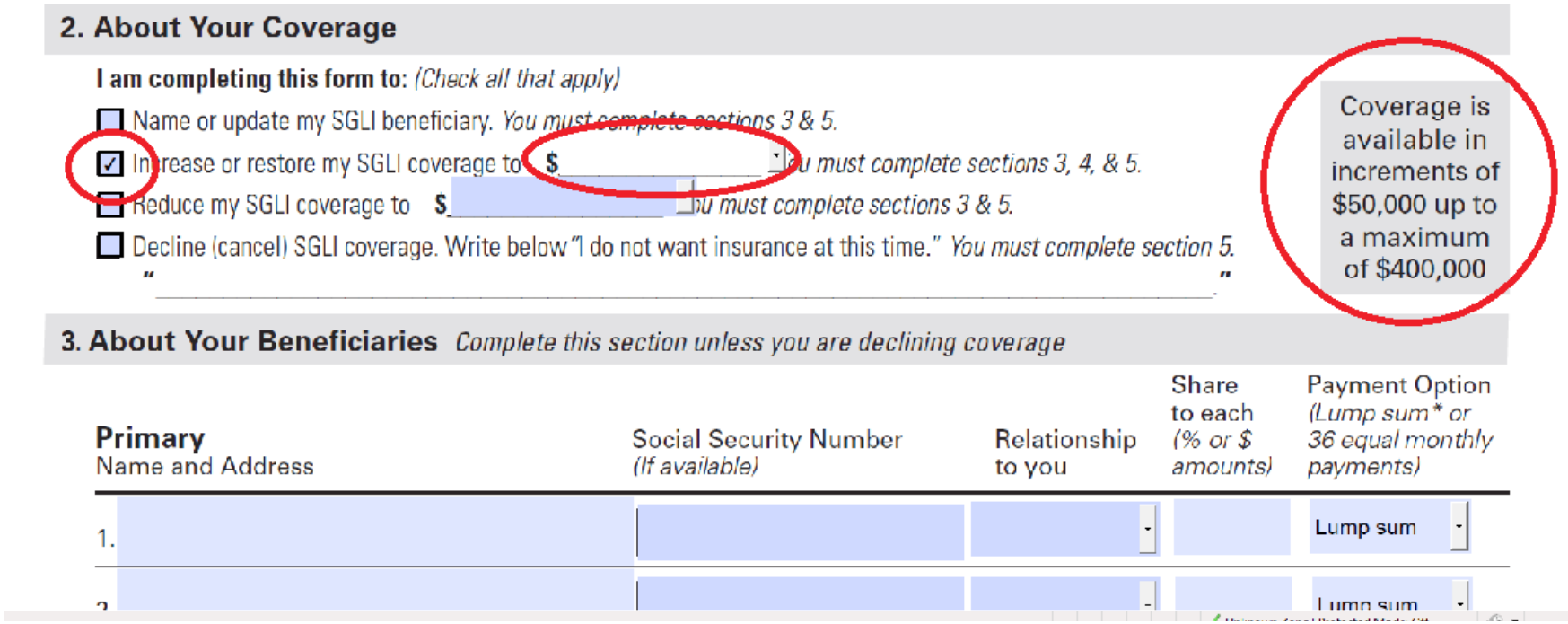
Coverage is available in increments of $50,000 up to a maximum of $400,000

3. About Your Beneficiaries *Complete this section unless you are declining coverage*

Primary Name and Address	Social Security Number *(If available)*	Relationship to you	Share to each *(% or $ amounts)*	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.				Lump sum

Increase/Restore Coverage

For those who have *previously* ***cancelled or reduced*** insurance



2. About Your Coverage

I am completing this form to: *(Check all that apply)*

- ☐ Name or update my SGLI beneficiary. *You must complete sections 3 & 5.*
- ☑ Increase or restore my SGLI coverage to $_____ *You must complete sections 3, 4, & 5.*
- ☐ Reduce my SGLI coverage to $_____ *You must complete sections 3 & 5.*
- ☐ Decline (cancel) SGLI coverage. Write below "I do not want insurance at this time." *You must complete section 5.*

"_____"

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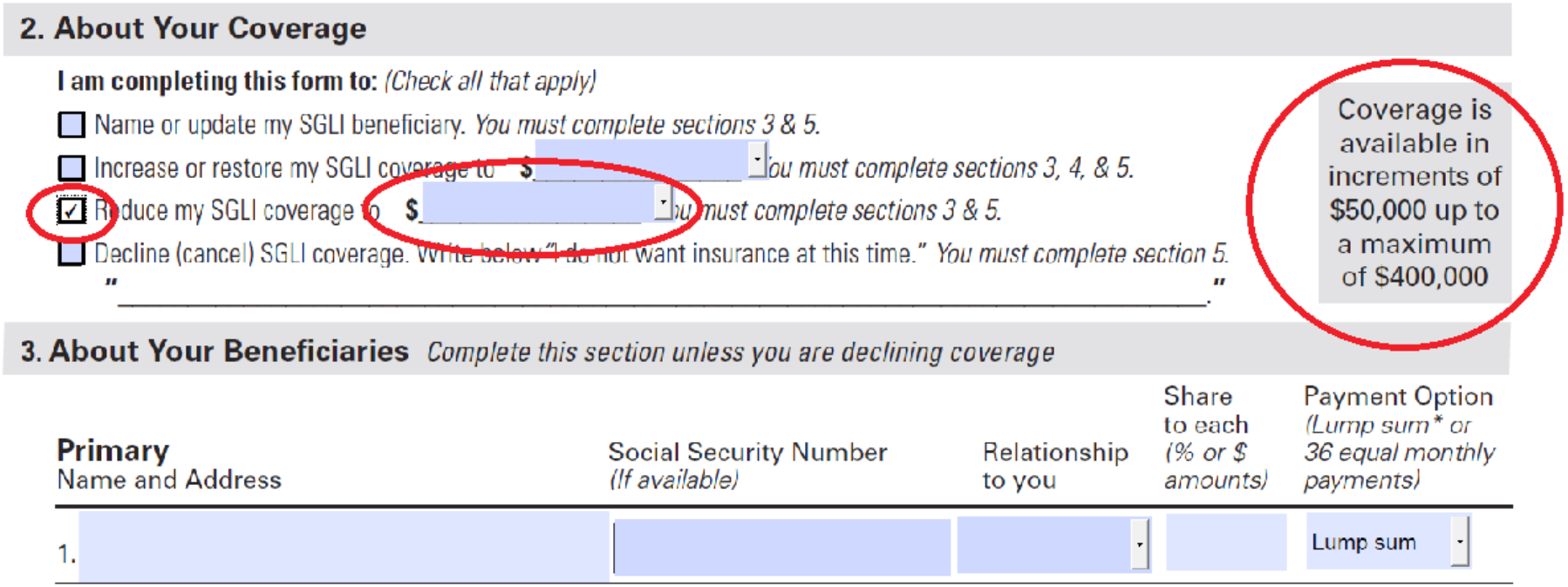
1.				Lump sum
2.				Lump sum

Reduce Coverage

To any amount less than $400,000



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- ☑ Reduce my SGLI coverage to $ _____ *ou must complete sections 3 & 5.*
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" _____ "

Coverage is available in increments of $50,000 up to a maximum of $400,000

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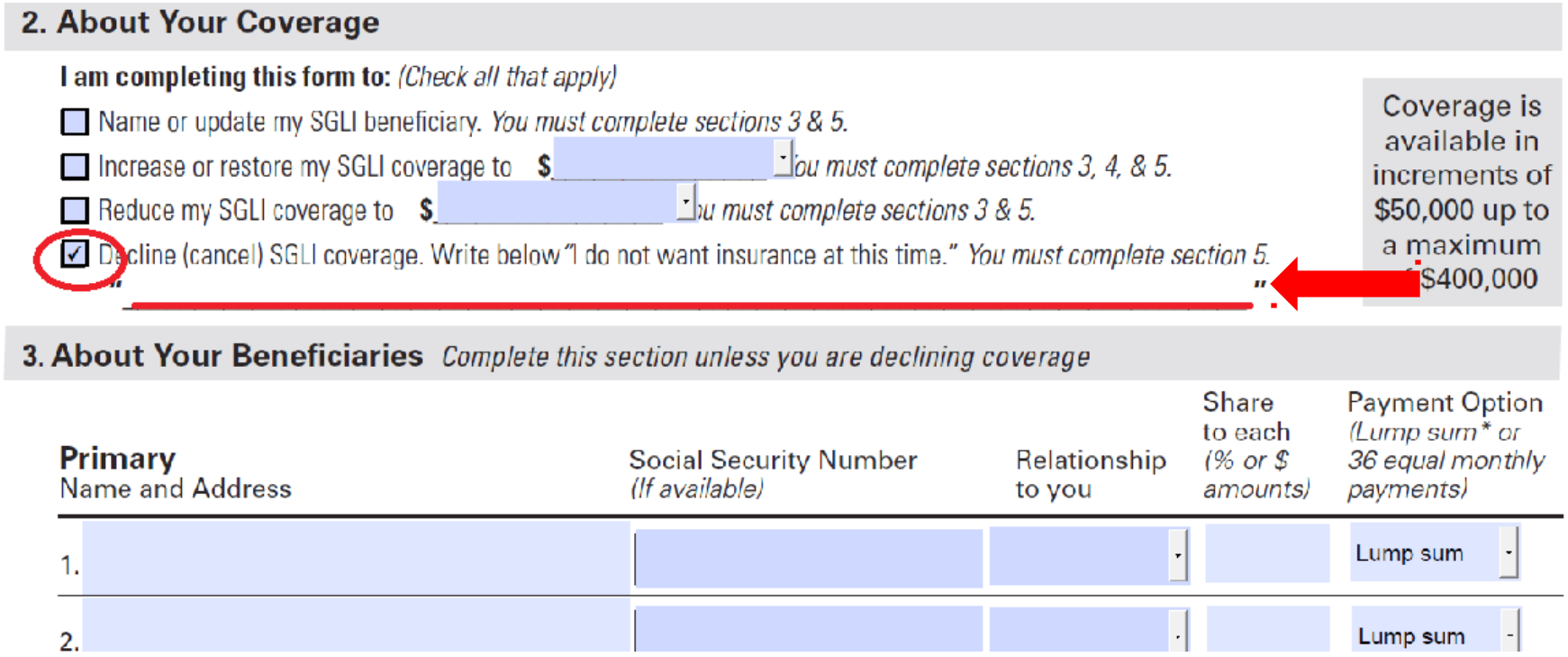
Primary Name and Address	Social Security Number *(If available)*	Relationship to you	Share to each *(% or $ amounts)*	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.				Lump sum

Decline Insurance

Please write "*I do not want insurance at this time*."

Proof of health will be required to reinstate SGLI Coverage



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- ☐ Reduce my SGLI coverage to $_____ *u must complete sections 3 & 5.*
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"_____"

Coverage is available in increments of $50,000 up to a maximum of $400,000

3. About Your Beneficiaries *Complete this section unless you are declining coverage*

Primary Name and Address	Social Security Number *(If available)*	Relationship to you	Share to each *(% or $ amounts)*	Payment Option *(Lump sum* or 36 equal monthly payments)*
1.				Lump sum
2.				Lump sum

Beneficiaries

Complete full names. All percentages must total 100%.

3. About Your Beneficiaries *Complete this section unless you are declining coverage*

	Name and Address	Social Security Number *(If available)*	Relationship to you	Share to each *(% or $ amounts)*	Payment Option *(Lump sum* or 36 equal monthly payments)*
Primary					
1.	Full First, Full Middle, Full Last 123 Schriever Way, Schriever AFB, CO 80910	000-00-0000	spouse	50%	
2.	Full first, Full Middle, Full Last 123 Schriever Way, Schriever AFB, CO 80910	000-00-0000	mother	50%	
3.					
4.					
Secondary					
1.	Full first, Full Middle, Full Last 123 Schriever Way, Schriever AFB, CO 80910	000-00-0000	father	100%	Lump sum
2.					Lump sum

= 100%

Health Questions

Only if you have *previously* ***cancelled or reduced*** *insurance*

4. About Your Health *Complete this section ONLY if you are restoring or increasing coverage.*

Your date of birth (MM, DD, YYYY)

Your weight

Your height

Your gender ☐ Female ☑ Male

Have you had, been treated for, or had known indications of:	**Yes**	**No**
a. A heart condition?	☐	☐
b. High blood pressure?	☐	☐
c. A neurological disorder?	☐	☐
d. Diabetes?	☐	☐
e. Cancer or tumors?	☐	☐
f. Have you ever been diagnosed as having a disease of the immune system?	☐	☐
g. Do you have any known physical impairments, deformities, or ill health not covered above?	☐	☐

Did you answer "YES" to any question? If so, reference the question by letter and list date, duration and details below.

Any request to increase coverage does not take effect until approved by OSGLI.

5. Your Signature *You must complete this section.*

Signature

Please state amount of SGLI coverage you currently have or are changing

5. Your Signature *You must complete this section.*

I have read the instructions and understand that:

- This form cancels any prior beneficiary or payment instructions.
- I can have SGLI and VGLI coverage at the same time, but the combined amount cannot be more than $400,000.
- Reducing or declining SGLI coverage can affect the amount of my family coverage, traumatic injury coverage and post-separation coverage (see instructions for details).
- If I am married or get married after completing this form and have not declined SGLI, Family SGLI automatically covers my spouse. I must register my spouse in DEERS so my branch of service can deduct premiums from my pay. *Failure to register my spouse in DEERS will result in my owing debts for unpaid premiums.* I can decline Family SGLI coverage by completing SGLV 8286A.
- I certify that the information provided on this form is true and correct to the best of my knowledge and belief. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

	000-00-0000	
Service Member Signature	Social Security Number	Date (MM, DD, YYYY)
Current Amount of SGLI	Address	

Amount you just signed up for or currently have

Family Coverage
(SGLI Spousal Insurance)

SGLI election automatically enrolls spouses for $100,000 coverage

- Do not need to complete if you want to keep spousal coverage of $100,000
- Complete if:
  - Changing (increasing/decreasing) coverage amount
  - Reinstating coverage after previously declining/cancelling

Prudential

Office of Servicemembers' Group Life Insurance

Family Coverage Election and Certificate

Part I – Service Member Information

1. Print Name (first middle last)	2. Social Security Number	3. Branch of Service
4. Amount of SGLI now in force	5. Amount of coverage desired for spouse	6. Rank, title or grade

Amount you currently have or just elected

Up to $100,000 in $10,000 increments
Not to exceed SGLI amount

Spouse Information

Only if you **have *previously cancelled*** **or *decreased***

- Do not complete:
  - if you are only reducing coverage to lower than $100,000

Part III – Spouse Information (to add or increase spouse coverage)

12. Weight in pounds	13. Height in feet and inches	14. Gender ☐ Female ☐ Male

15. Have you had or been treated for known indications of:	Yes	No	18. Did you answer "YES" to any question? If so, reference the question by letter and list date, duration, and details below.
a. A heart condition	☐	☐	
b. High blood pressure	☐	☐	
c. A neurological disorder	☐	☐	
d. Diabetes	☐	☐	
e. Cancer or tumors	☐	☐	
16. Do you have any known physical impairments, deformities, or ill health not covered above?	☐	☐	
17. Have you ever been diagnosed as having a disease or disorder of the immune system?	☐	☐	

The answers I have given are for securing approval of this request for insurance and I certify that they are true and correct to the best of my knowledge and belief. I understand that the insurance being requested requires approval of insurability by the Office of Servicemembers' Group Life Insurance. Any deception or knowingly false statement either by inference or omission may result in cancellation of the insurance or in the refusal to pay a claim.

19. Signature of spouse	20. Date

ONLY if you are ***restoring coverage*** or ***increasing*** coverage amount

If you are declining/changing Coverage

Prudential

Office of Servicemembers' Group Life Insurance

Part IV – Spouse Information (to reduce or decline spouse coverage)

Family Coverage – Spouse

By law, if you are insured under SGLI, **your spouse is automatically insured for $100,000 or the amount of your SGLI coverage**, whichever is less. ***If you want less than the automatic amount of coverage for your spouse***, please check the appropriate box below and write the amount desired and your initials. Coverage is available in increments of $10,000. ***If you do not want any coverage for your spouse***, check the appropriate box below and write (in your own handwriting), "I do not want coverage for my spouse at this time."

☐ I want spouse coverage in the amount of $_____.

☐ In the space below write: "I do not want coverage for my spouse at this time."

_____

Note: Family Coverage for Dependent Child(ren). By law, if you are insured under SGLI, each of your dependent children (see page 5 for a definition of dependent children for SGLI purposes) is automatically insured for $10,000.

Changed Amount

OR

Declining Coverage

Please sign Part V